STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185124	A. BUILDING _____ B. WING _____	C 04/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDBANKS	851 KIMSEY LANE HENDERSON, KY 42420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey (KY #23094) was conducted on 04/28/15 through 04/30/15. KY #23094 was unsubstantiated with unrelated deficiencies identified at the highest Scope and Severity of a "D".	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility policy and procedure, and review of the manufacturer's guidelines for a medication for inhalation (Symbicort), revealed the facility failed to ensure the services provided or arranged by the facility must meet professional standards of quality for one (1) unsampled resident (Resident #A). Licensed Practical Nurse (LPN) #1 administered an inhaler medication to Unsampled Resident A which required the resident to rinse and spit after the inhalation. LPN #1 did not instruct Unsampled Resident A to rinse and spit but gave him/her a glass of water and told him/her to drink it. The findings include: Review of the facility's policy and procedure, titled "Adverse Consequences and Medication Errors", last revised 02/2014, revealed a "medication error" was defined as the preparation or administration of drugs or biologicals which was not in accordance with physician's orders,	F 281		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/14/2015

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F 281	Continued From page 1	F 281		

manufacturer's specifications, or accepted professional standards of the professional(s) providing services".

Review of the Manufacturer's Specifications for the medication Symbicort (Asthma medication), (not dated), revealed after inhalation, the resident should rinse the mouth with water without swallowing.

Observation of a Medication Administration, on 04/29/15 at 8:20 AM, revealed LPN #1 administered Symbicort inhalation medication to Unsampled Resident #A and did not instruct the resident to rinse his/her mouth after inhalation.

Interview with LPN #1, on 04/29/15 at 9:00 AM, revealed after she gave Unsampled Resident #A the inhaler and she should have had the resident swish and spit after the puffs, but instead she had the resident drink and swallow.

Interviews with LPN #2, on 04/29/15 at 9:36 AM and LPN #3, on 04/29/15 at 1:48 PM, revealed, after administering an inhaler medication, they would have had the resident rinse his/her mouth after inhalation per the manufacturer's instructions.

Interviews on 04/29/15 with Registered Nurse (RN) #1 at 1:37 PM, RN #2 at 1:59 PM, and RN #3 at 2:10 PM, revealed they would have had the resident rinse and spit after inhalation of a medication.

Interview with the Director of Nursing (DON), on 04/29/15 at 12:57 PM, revealed LPN #1 should have instructed the resident to rinse and spit after the inhaler was given.

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F 281	Continued From page 2 Interview with the Assistant Administrator, on 04/29/15 at 2:08 PM, revealed she expected the nurse to follow the manufacturer's guidelines for a medication.	F 281		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		

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F 441	Continued From page 3 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This STANDARD is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection for one (1) unsampled resident (Unsampled Resident A). Licensed Practical Nurse (LPN) #1, dropped a pill on the floor during medication pass, picked the pill up off of the floor and did not wash her hands after she picked up the pill. The findings include: Review of the facility's policy and procedure, titled "Infection Control Guidelines for All Nursing Procedures", last revised 04/2013, revealed general guidelines stating "In most situations, the preferred method of hand hygiene was with an alcohol-based hand rub for the following situation (before preparing or handling medications). Observation of a medication pass, on 04/29/15 at 8:20 AM, revealed LPN #1 preparing medications to administer to Unsampled Resident A. LPN #1 dropped a pill on the floor, picked it up and proceeded to prepare the other medications	F 441		

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F 441	Continued From page 4	F 441		

without sanitizing her hands in between.

Interview with LPN #1, on 04/29/15 at 9:00 AM, revealed she knew she dropped a pill on the floor, laid it on the medication cart, and did not sanitize her hands.

Interviews on 04/29/15 with LPN #2 at 9:36 AM and LPN #3 at 1:48 PM, revealed if they dropped a pill on the floor they would pick it up, put it in the Sharps container and wash their hands.

Interviews on 04/29/15 with Registered Nurse (RN) #1 at 1:37 PM, RN #2 at 1:59 PM, and RN #3 at 2:10 PM, revealed if they dropped a pill on the floor, they would have picked it up, put it in the Sharps container, and sanitized their hands.

Interview with the Director of Nursing (DON), on 04/29/15 at 12:57 PM, revealed if a nurse dropped a pill on the floor, she expected the nurse to pick up the pill, put it in the Sharps container, and wash their hands.

Interview with the Assistant Administrator, on 04/29/15 at 2:08 PM, revealed she expected a nurse to wash their hands if they dropped a pill on the floor and picked it up.